STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445075	A. BUILDING _____ B. WING _____	C 09/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF MADISON	431 LARKIN SPRING RD MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint investigation #TN00055323, #TN00055282 and #TN00054869 was completed on 9/29/2021 at Signature Healthcare of Madison. Deficiencies were cited related to complaint investigation #TN00055323 and #TN00054869 under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Abuse Deficiency SHC Madison 9/29/21 Based on facility policy, medical record review, review of the Investigative Summary, and interview, the facility failed to prevent resident to resident abusive behaviors between 2 residents (#2 and #3) of 5 residents reviewed. The facility also failed to prevent verbal abuse for 1 resident (#7) of 5 residents reviewed.	F 600	Signature of Madison does not believe and do not admit that any deficiencies existed before, during, or after the survey. The facility reserves the right to contest the survey findings through informal dispute resolution, formal appeals proceedings, or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation, or position and the facility reserves the rights to raise all possible contentions and defenses in any type of civil or criminal claim, action, or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, Quality Assurance, or self-critical examination privilege which the facility does not waive and reserves the right to assert in any proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to its residents. RECEIVED OCT 26 2021 BY:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul A Smith, NHA — TITLE: Administrator — (X6) DATE: 10/26/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shalla Smith NHA | TITLE: Administrator | (X6) DATE: 10/26/2021

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F 600	Continued From page 1 The findings included: Review of facility policy Abuse, Neglect and Misappropriation of Property revised 5/18/19 revealed "...this policy presumes that all abuse as defined...caused physical harm, pain, or mental anguish to any resident even if he or she does not understand the incident or even if he or she is in a coma...allegation of abuse means a report, complaint...to mean abuse...has occurred...all alleged violations involving...neglect are reported immediately but no later than 2 hours after the allegation is made...neglect...failure to provide goods and services necessary to avoid physical harm, mental anguish, or emotional distress...interviews and reference checks will be conducted on all potential employees...criminal background check will be conducted prior to permanent employment...during orientation all new Stakeholder [employees]...will be trained on report allegation of abuse...each stakeholder...will receive annual training...every Stakeholder...must intervene immediately...to prevent or interrupt an incident of abuse..." Review of facility policy, Resident Rights, dated 8/16/16 revealed, " ...All residents have the right to be treated with respect and dignity. These rights will be promoted and protected by the facility...All residents will be treated in a manner and in an environment that promotes maintenance or enhancement of quality of life...When providing care and services, the stakeholders will respect the resident's individuality and value their input by providing them a dignified existence, through self-determination and communication with and access to persons and services inside and outside the facility..."	F 600	(b) Staff education was initiated and is ongoing concerning verbal abuse. Resident interviews were conducted on 9/29/21, and no further allegations were made. (c) Investigation was conducted per facility protocol. RN#1 has been removed from the facility's schedule. Administrator reported the allegation made against RN #1 to her agency for any further action needed. (4) Facility will continue to follow the Abuse Protocol and procedures related to Abuse, Neglect, and Mistreatment through routine observation rounds/interviews 5 days a week for 2 weeks to observe staff to resident interactions during care. If compliance is maintained, observation rounds will be conducted 3 times Per week for two weeks, then weekly for 4 weeks, then monthly thereafter until compliance is achieved for a minimum of 3 months. Audits will be reviewed by the Interdisciplinary Team (IDT) and plan will be revised if needed.	

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F 600	Continued From page 2 Review of the facility Investigative Summary, revealed the resident to resident incident occurred on 7/26/2021 at 4:23 PM and was reported by the Administrator to the State Unusual Incident Report System on 7/26/2021 at 4:57 PM. The investigation revealed Resident #3 hit Resident #2 on the arm. Further investigation revealed the residents were separated and there were no injuries noted. The report stated Resident #3 had a Brief Interview of Mental Status (BIMS) score of 4 and Resident #2 had a BIMS score of 15. Further review of the facility investigation revealed a witness statement, multiple skin assessments on residents throughout the building, resident interviews and staff in-service regarding abuse. Review of the medical record for Resident #2 revealed she was admitted on 12/11/2015, a readmission on 4/19/2019, with diagnoses which included Complete Traumatic Amputation at knee level, left lower leg, Hemiplegia and Hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side and Bipolar Disorder. Review of the Quarterly Minimum Data Set (MDS) dated 5/28/2021, revealed a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderate cognitive impairment. Review of the medical record for Resident #3 revealed she was admitted on 11/26/2019 with diagnoses which included Vascular Dementia with behavior disturbance, Schizoaffective disorder, Mood disorder, Restlessness and Agitation. Further review of the Quarterly MDS dated	F 600		

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F 600	Continued From page 3 5/24/2021 revealed a BIMS score of 4, which indicated severe cognitive impairment. Review of the Psychotherapy Progress Notes dated 2/8/2021-9/17/2021, revealed Resident #3 was seen by a Licensed Clinical Social Worker (LCSW) with focus which included aggressive behavior and poor impulse control. Review of the medical record revealed Resident #7 was admitted to the facility 10/20/2016 and readmitted 7/2/2019 with diagnoses which included Acute on Chronic Congestive Heart Failure, Adjustment Disorder, Edema, Generalized Muscle Weakness with Gait and Mobility Abnormalities, Lymphedema, Morbid Obesity due to Excess Calories, Dermatitis with Pruritis, and Non-pressure Chronic Ulcer of Skin. Review of the Quarterly MDS dated 8/26/2021, revealed a BIMS score of 15, which indicated no cognitive impairment. Resident #7 rejected care occasionally, every 4 to 6 days, and total care was required of 1 to 2 staff members for Activities of Daily Living (ADL)s. Review of the Physician's orders for Resident #7 dated 9/1/2021-9/27/2021 included, "Lidocaine ointment; 5%; amount: one application; topical. Special instructions: Apply to excoriated areas three times a day ..." Observation and interview on 9/28/2021 at 11:20 AM, in room #1 revealed CNA #4 and Registered Nurse (RN) #1 providing routine AM care. RN#1 stated that Resident #7 refused application of Lidocaine ointment on 9/27/2021. Resident #7 replied, "I did not refuse the Lidocaine, they don't have it." While standing at the foot of the bed, the nurse said to this surveyor, "Sometimes he may	F 600		

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F 600	Continued From page 4 have mental issues where he doesn't remember refusing care, but he does." The resident was rolled to his left side facing away from the nurse and surveyor. There was no indication, verbal or nonverbal, that the resident heard the nurse's comment at the time. During an interview on 9/29/2021 at 8:50 AM, Resident #7 stated, "I was so tore up yesterday that I cried off and on all day. I couldn't believe she (RN #1) said I have mental issues and do not remember things, right to my face. My feelings were hurt, and I was in pain too." During an interview on 9/29/2021 at 10:09 AM, with Director of Nursing, she confirmed the comment made by RN #1 in the presence of Resident #7, was verbal abuse. During an interview on 9/29/2021 at 10:46 AM, the Administrator confirmed the resident-to-resident abuse occurred.	F 600		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657	F657 483.21 (b)(2)(i)-(iii) Care Plan Timing and Revision (1) (a)The care plan for resident #3 was reviewed and revised on 8/4/2021 to address the individual needs of the resident pertaining to the resident-to-resident altercation which occurred on 7/26/2021. Resident #3's comprehensive care plan addresses a history of behaviors Which include: verbal/physical aggression; refusing ADL Care; throwing water; yelling; screaming; kicking; combativeness; punching, sad, and withdrawn. Resident #3's care Plan was reviewed and revised on 10/25/2021 to reflect new Intervention: Staff to redirect resident away from highly trafficked areas as needed.	11/13/21

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F 657	Continued From page 5 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on facility policy, medical record review, interviews, and observations, the facility failed to update the care plan of 2 residents (Residents #3 and 4) of 7 residents reviewed. The findings included: Review of the facility policy titled, "Comprehensive Care Plan" dated 4//6/15 and last reviewed 4/14/21, revealed, "...A person-centered Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, mental and psychological needs is developed or each resident. The care plan will include how the facility will assist the resident to meet their needs, and preferences...Care plans are ongoing and revised as information about the resident and the resident's condition change...The nurse/Interdisciplinary Team is responsible for the review and updating of care plans. The care plan should reflect the current status of the resident and be updated with changes in the residents status..."	F 657	(b) The care plan for resident #4 was reviewed and revised on 9/29/2021 by the wound care nurse to correct the incorrect staging of the area that was identified on 9/11/2021 and classified as a stage II pressure ulcer. (2) A care plan audit was initiated by licensed nurses on 10/20/21 and is ongoing to ensure residents with behaviors have interventions in place for any behaviors that have been exhibited. (3) (a) Education has been initiated for staff to redirect resident #3 away from highly trafficked areas. (b) Education was conducted by the Signature Care Consultant with the Interdisciplinary Team regarding timely revision of care plans related to behaviors, skin conditions, and other changes of condition on 10/26/2021. Education will also focus on individualized interventions that are appropriate and person-centered. (c) Education was provided to nursing personnel beginning 10/26/2021 related to care plan development and revision, along with examples of interventions associated with aggressive behaviors and skin conditions. (4) IDT will audit a minimum of 15 resident care plans per week until all resident care plans have been reviewed and revised. Any changes in resident's condition will be discussed in the clinical whiteboard meeting Monday-Friday and care plan will be revised as needed. Facility will conduct random audits of 5 residents per week for 2 weeks, then 2 residents per week for 2 weeks, then 5 random residents per month for 2 months or until compliance Is achieved. Audits will be reviewed by IDT in facility's QAPI meetings and plan will be revised if needed.	

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F 657	Continued From page 6 Review of the medical record for Resident #3 revealed she was admitted on 11/26/2019 with diagnoses which included Vascular Dementia with behavior disturbance, Schizoaffective disorder, Mood disorder, Restlessness and Agitation. Review of the Quarterly MDS dated 5/24/2021, revealed a BIMS score of 4, which indicated severe cognitive impairment. Resident had mood symptoms 12-14 days over the previous 2 weeks, required extensive assist with bed mobility, transfer, bathing and hygiene, received Antipsychotic and Antidepressant medications 7 of 7 days. Review of the Comprehensive Care Plan revealed assessments for, "...Behavior: 7/26/2021- Resident was observed hitting another resident on this date. Both residents were immediately separated and assessed with no injuries noted..." The "Approach Start Date" dated 7/26/2021 revealed, "...Encourage resident to maintain personal space with other residents to avoid any negative interactions..." Review of the Psychotherapy Progress Notes dated 2/08/2021-9/17/2021, revealed she was seen by a Licensed Clinical Social Worker (LCSW) with focus which included aggressive behavior and poor impulse control. Review of the progress note dated 4/09/2021 revealed "...Nurse noted some recent aggression this morning towards staff and other resident...took several hours for her to sufficiently calm..." Progress note dated 2/08/2021 revealed "...she has been swatting at people when they go by her wheelchair as she sits in the hall way (hallway)..." Review of the Progress Notes revealed "...8/11/2021 5:00 Patient yelled out at another male resident that was parked in wheelchair in the hallway in front of her door...8/06/2021 3:13...Patient tried to throw a glass of water at male resident tonight but water	F 657		

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F 657	Continued From page 7 only hit med cart and floor...8/04/2021 13:51 (1:51 PM)...Late Entry for 7/26/2021: Resident was observed by staff...hitting another resident as they were trying to move past her while in the hallway..." Medical record review for Resident #4 revealed an admission date of 10/30/2020 with diagnoses which included Cerebral Infarction, Aphasia, Contracture of Right Elbow and Right Knee, Major Depressive Disorder and Anemia. Review of the Quarterly MDS dated 7/26/2021 revealed he had no visual or hearing impairments, rarely understood and rarely understands others, he has no speech, unable to participate in a BIMS due to severely impaired cognition and is extensive to total assistance for all Activities of Daily Living including eating. Review of the Physician Order Report dated 02/01/2021 - 9/27/2021, revealed physicians orders for, "...TX: R BUTTOCK: CLEANSE W NS OR WOUND CLEANSER, PAT DRY, APPLY SKIN PREP TO PERI WOUND. COVER W HYDROCOLLOID Q DAY AND PRN SOILING, SATURATION OR ACCIDENTAL REMOVAL..." Review of the Wound Care Notes dated 9/11/2021 revealed the identification of a Stage 2 Pressure Ulcer measuring 7.5 cm (centimeters) X 5 cm. Further review of the notes revealed, "...9/29/2021 Wound determined to be excoriation, rather than Stage 2, order changed to daily dressing..." Review of the Care Plan dated 6/8/2020 for Resident #4 revealed assessment for, "...Risk for pressure ulcer and skin breakdown development due to the following potential causative factors: decreased in overall functional mobility status; incontinence of both bladder and bowel****with dx (diagnosis) of s/p (status post) cva (cerebral vascular accident) right sided hemiplegia. Dx	F 657		

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F 657	Continued From page 8 Atopic Dermatitis right hip/buttock ..." Further review of the Goal dated 11/09/2021 revealed, "...Skin will be intact, free of redness, blisters, discoloration or open areas over bony prominence through the next review date..." During an interview on 9/29/2021 at 10:15 AM with the Director of Nursing, she confirmed the care plan was not updated for Resident #4 regarding a wound that developed on 9/11/2021. During an interview on 9/29/2021 at 10:46 AM with the Administrator, she confirmed the intervention placed on Resident #3's care plan, was not an appropriate intervention for a resident with a BIMS score of 4.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observations and interview, the facility failed to obtain physician's orders for foley catheters and a colostomy for 2 (Residents #1 and 5) of 5 residents reviewed. The findings include:	F 684	F684 CFR 483.25 Quality Of Care (1)(a) Resident #1's physician orders were reviewed and revised on 9/29/2021. Resident #5's physician orders were reviewed and revised on 10/26/2021. (2) IDT performed an audit of the physician orders for all residents with indwelling catheters and ostomies on 10/26/2021 and orders were revised as needed. (3)(a) Licensed nurses were re-educated beginning on 10/27/2021 and ongoing to enter complete orders for indwelling catheters and ostomies. (b) IDT will review residents with indwelling catheters and ostomies during weekly At Risk meetings for 3 months to ensure accuracy of orders. (4)IDT will audit residents' orders during the clinical whiteboard meetings held Monday – Friday to ensure orders are complete, to include the size of the indwelling catheter. IDT will report all findings to the QAPI committee to include the Administrator, Director of Nursing, Medical Director, and designee(s) and review or revise the plan as needed.	11/13/21

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F 684	Continued From page 9 Review of facility policy titled, "Review of Physicians Orders" dated 6/1/15 and last reviewed 4/14/21 revealed, "...It is the standard of this facility that physician orders are reviewed daily to ensure delivery of applicable care, tracking of change in condition and updating of care plans are consistently provided...Residents will be added to respective tracking logs...as indicated, i.e., labs, psychotropic, restraint, etc..." Review of medical record for Resident #1 revealed an original admission date of 10/27/2020, a readmission date of 4/9/2021, with diagnoses which included, Acute and Chronic Respiratory Failure with Hypoxemia, Tracheostomy and Ventilator Dependent, and Quadriplegia C5-C7 Complete. Review of the Quarterly Minimum Data Set (MDS) dated 7/14/2021 revealed he had no impairment of vision or hearing, he is able to make self understood and understands others, he has a Brief Interview for Mental Status (BIMS) score of 15, which indicated he was cognitively intact, he had exhibited no behaviors, including refusal of care or treatment, he was totally dependent upon staff for all care, including eating, and he had a urinary catheter and colostomy. Review of the Physician Order Report for Resident #1 dated 9/1/2021-9/28/2021 revealed orders for medications and treatments, but no orders for an indwelling Foley Catheter or Colostomy. Review of the medical record for Resident #5 revealed an admission date of 6/23/2021 with diagnoses which included Infection and Inflammatory Reaction due to Indwelling Urethral Catheter, Multiple Sclerosis and Toxic Encephalopathy. Review of the Quarterly MDS dated 7/2/2021, revealed a BIMS score of 13,	F 684		

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	445075	A. BUILDING _____ B. WING _____	C 09/29/2021

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F 684	Continued From page 10 which indicated no cognitive impairment. Further review revealed extensive assistance of 1 to 2 staff members for all Activities of Daily Living and the presence of an indwelling catheter and ostomy. Review of Resident Progress Notes dated 9/19/2021 revealed, "...she has colostomy and suprapubic cath, she needs total care for all ADL's..." Review of the Physician Order Report dated 8/27/2021-9/27/2021 revealed physician's orders for medications, treatments and colostomy, but no orders for suprapubic catheter. Observation on 9/28/2021 at 1:45 PM in Resident #1's room, revealed resident laying on his back in bed on an air mattress with head of bed elevated. Quarter side rails were up to the head of the bed. The resident had Foley Catheter secured to a leg strap on his right thigh, and a urinary collection bag to the left side of his bed. The resident was also observed with a colostomy to the lower left side of his abdomen. During an interview on 9/29/2021 at 09:58 AM with the Director of Nursing, she confirmed Resident #1 did not have an order for an indwelling Foley Catheter or a Colostomy. During an interview on 9/29/2021 at 10:00 AM with the Director of Nursing, she confirmed Resident #5 was currently in the hospital, and had not had an order for an indwelling Suprapubic Catheter.	F 684		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755	F755 CFR Pharmacy Services/ Procedures/ Pharmacist/ Records (1) Resident #7's medicated topical cream was obtained from a backup pharmacy on 9/28/2021. (2) Signature Care Consultant conducted an audit of all residents with orders for topical analgesics to ensure medications were available on 9/29/2021. A review of residents' MARs was also completed to identify any omissions due to unavailability of medications on 10/7/2021 and visualized the availability of medications	11/13/21

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F 755	Continued From page 11 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on facility policy, medical record review, observations and interviews, the facility failed to provide or obtain medications for 1 (#7) of 3 residents reviewed. The findings included: Review of undated facility policy titled "Non-Controlled Medication Orders" revealed,	F 755	ordered were present on the medication cart. None were identified. (3) Licensed nurses were in-serviced by Staff Development Coordinator beginning on 9/29/2021 to check the emergency backup kit and obtain medications that are not available on the medication cart. If not available in the emergency backup kit, the nurse is to notify the backup pharmacy and obtain the medication. If medication is not available from the backup pharmacy, then staff are to notify the physician and obtain an order for an alternate medication until facility's pharmacy delivers the medication. (4) IDT will audit the MARs of residents with topical analgesic orders daily M-F in clinical whiteboard to identify any omissions. IDT will validate that ordered topical analgesics are present and available on medication carts.	

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F 755	Continued From page 12 "Emergency/STAT medication order when medication is not available in the emergency kit: An emergency/STAT order is placed with the provider pharmacy and the medication is scheduled to be given as soon as received. Subsequent doses are timed according to nursing care center policy on medication administration schedule..." Review of the medical record for Resident #7 revealed an admission date of 10/20/2016 and was readmitted on 7/2/2019 with diagnoses which included Acute or Chronic Diastolic (Congestive) Heart Failure, Type 2 Diabetes Mellitus Without Complications, Adjustment Disorder, Edema and Morbid Obesity. Review of the Quarterly Minimum Data Set (MDS) dated 8/26/2021 revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. Review of the physician's orders dated 9/1/2021-9/27/2021 revealed an order for Lidocaine Ointment 5%. Apply to excoriated areas three times a day, ordered 9/4/2021. Review of the Medication Administration Record (MAR) dated 9/1/2021 -9/29/2021 revealed the medication was marked "unavailable" on 9/11/2021 at 07:00 AM-11:00 AM, 9/11/2021 at 11:15 AM-15:00 (3:00 PM), on 9/12/2021 at 07:00 AM- 11:00 AM, on 9/12/2021 at 11:15 AM-15:00, on 9/13/2021 at 07:00 AM-11:00 AM, and on 9/28/2021 at 07:00 AM-11:00 AM (comment: Not Administered: Needs reordering.) Observation and interview on 9/28/2021 at 11:20 AM, in room #1 revealed CNA #4 and Registered Nurse (RN) #1 providing routine AM care. RN#1 stated the Lidocaine ointment was not available to apply during the care. The RN continued to say, Resident #7 refused application of Lidocaine	F 755		

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F 755	Continued From page 13 ointment on 9/27/2021. Resident #7 replied, "I did not refuse the Lidocaine, they don't have it." There were no wounds observed during care. There was excoriation noted on buttocks and treatment was applied. During a telephone interview on 9/27/2021 at 10:03 AM, the Ombudsman stated, "I spoke with the Resident regarding the complaint...they are not supplying my medication like they should..." During an interview on 9/29/2021 at 8:45 AM, with Licensed Practical Nurse (LPN)#1, she confirmed Resident #1 has orders for Lidocaine ointment to be applied three times a day and that the medication was unavailable to administer that morning. During an interview on 9/29/2021 at 8:55 AM, a Unit Manager stated "...he (Resident #7) should not be out of the Lidocaine, I will look in the med room..." During further interview at 11:20 AM, he confirmed the medication was not available. The Unit Manager stated the nurses usually order when a medication is needed or running low. During an interview on 9/29/2021 at 10:09 AM, the Director of Nursing stated if a resident is out of a medication the nurse will order it or call pharmacy. During further interview she confirmed the medication for Resident #7 should be available either from pharmacy, emergency supply or back up pharmacy. She added that she expects residents in the facility to have medications available if there are orders for them.	F 755		